



MHD Mental Health Division

COMMUNITY MENTAL HEALTH SERVICES
APPLICATION FOR LICENSE

PROVIDER NAME	LEGAL ENTITY	
ADDRESS		
ADMINISTRATOR'S NAME	TELEPHONE NUMBER (INCLUDE AREA CODE)	
<input type="checkbox"/> Governmental <input type="checkbox"/> Proprietary <input type="checkbox"/> Other		
COMMUNITY SUPPORT SERVICES APPLIED FOR: (NON-RESIDENTIAL) CHECK APPLICABLE BOX(ES).		
<input type="checkbox"/> Emergency Crisis Intervention Services – WAC 388-865-0452 <input type="checkbox"/> Case Management Services – WAC 388-865-0456 <input type="checkbox"/> Psychiatric Treatment, including Medication Supervision – WAC 388-865-0458 <input type="checkbox"/> Counseling and Psychotherapy Services – WAC 388-865-0460 <input type="checkbox"/> Day Treatment – WAC 388-865-0462 <input type="checkbox"/> Consumer Employment Services – WAC 388-865-0464 <input type="checkbox"/> Peer Support Services WAC 388-865-0453		CURRENT LICENSE STATUS <input type="checkbox"/> New <input type="checkbox"/> Renewal
NUMBER OF ANNUAL CONSUMER SERVICE HOURS		
<input type="checkbox"/> CRISIS TELEPHONE SERVICES ONLY – WAC 388-865-0454 (Non-Community Support)		
DEPARTMENT OF HEALTH LICENSE NUMBER	TYPE OF LICENSE	EXPIRATION DATE
LIST ONLY THOSE RESIDENTIAL SERVICES WHERE APPLICANT PROVIDES BOTH THE FACILITY AND THE MENTAL HEALTH CARE.		
DECLARATION		
This application for licensure signifies readiness of the provider to meet the requirements of the laws of Washington State and the Washington Administrative Code including Revised Code of Washington (RCW) 71.05, 71.24, 71.34 and WAC 388-865. I declare that the information given in this application is true to the best of my knowledge and belief.		
ADMINISTRATOR'S SIGNATURE	DATE	ADMINISTRATOR'S NAME AND TITLE
GOVERNING BODY SIGNATURE	DATE	GOVERNING BODY NAME AND TITLE
REGIONAL SUPPORT NETWORK (RSN) APPROVAL		
My signature represents Regional Support Network approval of this application. I will notify the department of observations that this provider may not be in compliance with licensing requirements.		
NON-RSN COUNTY OR RSN REVIEWER'S SIGNATURE	DATE	NON-RSN COUNTY OR RSN REVIEWER'S NAME AND TITLE